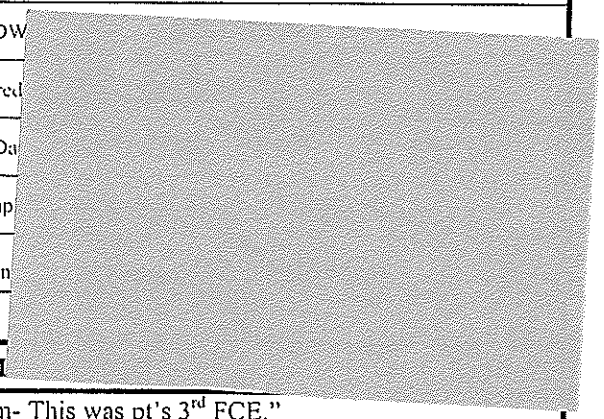
Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Southwest Center Medical 7125 Marvin D. Love #107 Dallas, TX 75203	MFDR Tracking #: M4-08-3646-01 DW Injured Da
Respondent Name and Box #: TASB Risk Management Fund Rep. Box #: 47	Emp Insuran



PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUM

Requestor's Position Summary: "Carrier denied stating only 3 FCEs allowed per claim- This was pt's 3rd FCE."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $579.84
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "...As indicated on the explanation of reviews, the charges for 97750-FC were denied on the basis that the Requestor exceeded the amount of FCEs that are allowed to be reimbursed per claim."

Principle Documentation:

1. Response to DWC 60

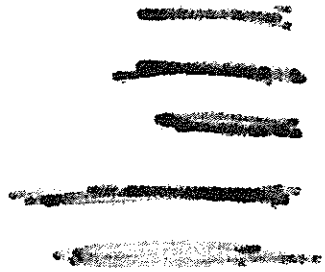
PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
03/15/07	97750-FC ($28.99 x 125% = $36.24 x 12)	119	1 – 3	$434.88
Total Due:				$434.88

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "119 – Benefit maximum for this time period or occurrence has been reach. Per Rule 134.202, a maximum of 3 FCE's are to be reimbursed per claim."
2. According to Division Rule 28 Texas Administrative Code Section 134.202(e)(4) a maximum of three FCE's are allowed for each compensable injury. Per Division Rule 28 Texas Administrative Code Section 133.307(d)(2)(A)(iii) the Respondent did not submit pertinent documents to support their claim.



3. The Requestor billed four hours for the FCE performed on the disputed date of service. According to Division Rule 28 Texas Administrative Code Section 134.202(e)(4) reimbursement shall be for up to a maximum of four hours for the initial test; a maximum of two hours for an interim test; and a maximum of three hours for the discharge test, unless it is the initial test. The Requestor has stated that this is the 3rd FCE administered to the claimant. Therefore, reimbursement is recommended for three hours in the amount of $434.88.

4. Per review of Box 32 on CMS-1500, zip code 75237 is located in Dallas County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 133.307, 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $434.88 plus applicable accrued interest per Division Rule 134.130, due within 30 days of receipt of this Order.

ORDER:

[redacted] Authorized Signature

[redacted] Medical Fee Dispute Resolution Officer

03/14/08 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.